MARYLAND HEALTH CARE COMMISSION

Required Under Section 15-1502 of the Insurance Article

Study of Mandated Health Insurance Services: A Comparative Evaluation

January 15, 2004

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Study of Mandated Health Insurance Services: A Comparative Evaluation (Required Under Section 15-1502 of the Insurance Article)

In 1999, the General Assembly passed SB 625 "Mandated Health Insurance Services – Cost Determination" to require the Commission to assess the fiscal impact of current mandates in consideration for a state-mandated affordability cap of 2.2% of Maryland's average annual wage. Since 1999, the MHCC has contracted with Mercer to perform this analysis annually.

The 2003 General Assembly passed HB 605 which, effective July 1, 2003, repealed Section 15-1502 of the Insurance Article which required the Commission to evaluate the social, medical and financial impact of all Maryland mandated services if the 2.2% affordability cap was exceeded. Instead, the bill requires the MHCC to conduct an evaluation of existing mandated services and report to the General Assembly by January 1, 2004, and every four years thereafter. A copy of Section 15-1502 is included in Exhibit 2. Under Section 15-1502, the evaluation must include:

- An assessment of the full cost of each existing mandated service as a percentage of the State's average annual wage and of premiums for the individual and group health insurance market

- An assessment of the degree to which existing mandated services are covered in self-funded plans

- A comparison of mandated services required in Maryland with those required in Delaware, the District of Columbia, Pennsylvania, and Virginia, including the:
    - Number of mandated health insurance services
    - Type of mandated health insurance services
    - Level and extent of coverage for each mandated health insurance service
    - Financial impact of differences in levels of coverage for each mandated health insurance service.

The bill also requires the Commission to make recommendations to the General Assembly regarding decision-making criteria for reducing the number of mandates or the extent of coverage.

Summary of Evaluation

The MHCC contracted with Mercer Human Resource Consulting (Mercer) to perform the background analysis necessary to assist the Commission in developing its recommendations (see attached report by Mercer).

The Mercer report addresses the three evaluation criteria defined under HB 605. Because the MHCC can exempt the small group Comprehensive Standard Health Benefit Plan (CSHBP) from benefit mandates, their analysis of the group market focuses on insured groups with over 50 employees. Mandated benefits apply both to fully insured large groups and to the individual market. The Mercer report first looks at the full cost of the insurance mandates. Then it looks at the voluntary compliance rate of self-funded health plans that are exempt from mandates under ERISA. The voluntary compliance rate is used to estimate the portion of services that would be covered in the absence of these mandates. Mercer defines the balance of costs that would not be covered voluntarily as the marginal cost of the mandate. They then compare Maryland's mandates to the mandates of Delaware, the District of Columbia, Pennsylvania, and Virginia to see if their mandates differ and the financial impact of the difference. The Mercer report focuses on the 40 mandates included under Maryland Insurance Article Sections 15-801 through 15-840.

The following resources are used in the assessment:

- Mercer-conducted surveys of health plans as to current practices
- Mercer databases on indemnity and managed care plans
- Surveys of self-insured groups on voluntary coverage of mandates conducted by Mercer
- Mandate-specific research by Mercer's consultants.

Excluding the CSHBP, the full cost of current mandates equals about 15% of premium. This equals about 3.3% of the Maryland average annual wage for individual contracts and about 2.4% for group contracts.

While self-funded plans are exempt from Maryland insurance mandates, they commonly cover services to the same extent as required by the mandates. Overall, self-funded plans voluntarily cover 90% of the cost of mandated services. The one mandate that most self-funded employers exclude or cover to a lesser degree is the mandate for in vitro fertilization (IVF).

The marginal cost equals about 10% of the full cost based on the practices of self-funded plans. **Excluding the CSHBP, the marginal cost of current mandates equals about 1.6% of premium.** This equals about 0.3% of the Maryland average annual wage for individual contracts and about 0.2% for group contracts.

When comparing Maryland's mandates to those required by other states in the area, we see that most of the mandates are included in the mandates of at least one of the states.

However, for the services addressed by Maryland's mandates, the other states tend to require less extensive coverage. Overall, the financial value of these mandates for Delaware, the District of Columbia, Pennsylvania, and Virginia is between 57% and 73% of the value of Maryland's mandates. The greatest difference is consistently seen across all states with the IVF mandate, in both full and marginal cost.

There are six benefit mandates that are required in some of the neighboring states but are not required in Maryland. The potential full cost of these six mandates is up to 3.3% of premium. However, insured plans in Maryland already comply with these six mandates so there is no marginal cost associated with these additional mandates.

Recommended Options for Decision-Making Criteria

Based on Mercer's analysis, the Commission has developed the following recommended options for reducing or eliminating mandates in Maryland:

I. Recodify more appropriately the mandates that are currently found under Title 15, Subtitle 8 of the Insurance Article.

Much debate exists around the number of mandated benefits that Maryland has enacted. Mandated benefits, in general, are benefits that, by State law, must be included in a health insurance policy or contract. Mandated benefits fall into four categories: (1) health care services or treatments; (2) health care professions that are entitled to reimbursement; (3) coverage eligibility requirements for dependents or other related individuals; and (4) conversion or continuation of benefits requirements.[1] In addition, some statutory provisions that impose requirements on how an insurer must conduct business are considered mandates (i.e., a requirement that a carrier have a process for permitting a policyholder to petition for a prescription drug not on the carrier's formulary list), but these should not be considered mandated services.

The law that requires the Commission to evaluate mandates in Maryland specifies that it is mandated "services" that should be evaluated. Beginning with the first evaluation of mandated services in Maryland, the Commission and Mercer have interpreted those mandates to be those found in Sections 15-801 to 15-840 of the Insurance Article, thus Maryland currently is reported to have 40 mandated services.

[1] Greg Scandlen, "The Changing Environment of Mandated Benefits," in Government Mandating of Employee Benefits, ed. by the Employee Benefit Research Institute (Washington, D.C.: 1987), pp. 177-183. Scandlen uses this four part scheme by roughly equating each category to "what" (services); "where" (providers); "who" (dependents); and "when" (conversion/continuation). While other sources combine "dependents" and "conversion/continuation" into a "special population" category and, therefore, have only three categories, a more concise vision of benefit types may be achieved by utilizing Scandlen's methodology.

Using a more appropriately stringent definition of what should be considered a mandated service, seven of the mandates that are currently being included in Maryland's 40 mandates should not be considered "services." These mandates would include:

- Reimbursement for pharmaceutical products (§15-805);
- Choice of pharmacy for filling prescriptions (§15-806);
- Benefits for disability caused by pregnancy or childbirth (§15-813);
- Allow 90-day supply of maintenance drugs in single dispensing (§15-824);
- Referrals to specialists (§15-830);
- Requirement for procedure to allow for drugs or devices not on carrier's formulary (§15-831); and
- Extension of benefits (§15-833).

II. If Maryland wants to be more like surrounding states in terms of the number of mandates and the extent of coverage of existing mandates (not including mandated "offerings" nor the seven mandates listed in Section I above that are not "services"), the following changes could be made:

A. Eliminate coverage for services not covered by the four surrounding states (see pages 19-33 of Mercer Report). This strategy would include eliminating mandates for:

- in vitro fertilization services;[*]
- outpatient services and second opinions;
- prosthetic devices and orthopedic braces;
- osteoporosis prevention and treatment;
- detection of Chlamydia;
- habilitative services for children under 19 years of age;
- hair prosthesis for hair loss from chemotherapy or radiation cancer treatment;
- hearing aid coverage for a minor child; and
- medically necessary residential crisis services.

The elimination of all of these mandates would result in savings of 1.5% of premium based on the full cost of the mandates and 0.7% of premium based on the marginal cost of the mandates.

B. Reduce the extent of all mandates to the minimum level of coverage required in other states which are less than Maryland. Based on the <u>full</u> cost of the mandate having 0.5% of premium or greater savings using the <u>minimum</u> level covered in another state (see page 14 of Mercer Report), this strategy would include reducing or eliminating mandates for:

[*] The Commission received 24 written comments opposing the elimination of the IVF mandate.

- mental health and substance abuse;
- blood products;
- in vitro fertilization services;*
- osteoporosis prevention and treatment;
- prostate cancer screening; and
- morbid obesity treatment.

The reduction of all of these mandates to the minimum level covered in another state would result in a savings of 5.0% of premium based on the full cost of the mandates and 1.0% of premium based on the marginal cost of the mandates.

It should be noted that all these reductions would likely not achieve the savings predicted due to existing coverages in self-funded plans. In a competitive work environment, coverage in self-funded plans becomes the de facto coverage in other markets with or without mandates as fully-insured employers must provide similar benefits as they compete for the same workers. In effect, even if these mandates were reduced, only marginal cost savings would likely be achieved rather than the full cost savings.

III. Reduce or eliminate only the most costly mandates in Maryland based on either the full cost of the mandate (see page 3 of the Mercer Report) or the marginal cost (see page 9 of Mercer Report). Analysis of the cost of mandated services with a full cost of 0.5% of premium or greater shows the following would fall into this category:

- mental health and substance abuse;
- blood products;
- in vitro fertilization services;*
- hospitalization benefits for childbirth;
- length of stay for mothers of newborn;[2]
- mammograms;
- child wellness;
- diabetes equipment, supplies and self-management training;
- osteoporosis prevention and treatment;
- prostate cancer screening; and
- morbid obesity treatment.

Analysis of the cost of mandated services with a marginal cost of 0.5% of premium or greater shows the following would fall into this category:

- mental health and substance abuse; and
- in vitro fertilization services.*

* The Commission received 24 written comments opposing the elimination of the IVF mandate.
[2] This mandate is also a federal requirement.

The difference between these two lists (one based on the full cost and the other on the marginal costs) shows that almost all of these services are being provided by self-funded employers. If the mandates listed above based on the full cost of the service were eliminated from law, it is likely that they would be requested by employers to maintain a competitive benefit package. Many of these preventative services are sought by employers and provided by carriers because they are associated with long-term savings.

The elimination of all of these mandates would result in a savings of 12.8% of premium based on the full cost of the mandates and 1.2% of premium based on the marginal cost of the mandates. A reduction in the extent of coverage would generate lesser savings.

IV. If Maryland wants to eliminate those mandates least likely to be covered by self-funded plans (see page 6 of the Mercer Report), then Maryland should consider eliminating the mandate for in vitro fertilization services.[*] The elimination of this mandate would result in a savings of 0.8% of premium based on the full cost of the mandate and 0.7% of premium based on the marginal cost of the mandate.

V. Maryland could eliminate specified mandates from all coverage or create more plans exempt from mandates for low income individuals (i.e., a "basic" plan). (For a discussion of issues related to the creation of a "basic" benefit plan, see the MHCC report required under SB 477 [2003] on the feasibility of a "basic" plan in the small group market).

VI. Maryland could eliminate specific mandated services and replace them with a generic list of services. An example of such a generic list would be the federal guidelines for those services that are required to be offered by a federally-qualified health maintenance organization. The extent of coverage could be determined by the carriers. While this option could lead to more innovation on the part of carriers in benefit design, it could also lead to the development of products that purport to include certain benefits but are very minimal. This could lead to a case of "buyer beware." To assure a certain level of coverage, a regulatory body could be charged with determining whether the coverage being provided is adequate and appropriate.

VII. If Maryland wants to leave all mandates in place, a survey could be required of the surrounding states for each proposed coverage prior to adopting additional mandates.

[*] The Commission received 24 written comments opposing the elimination of the IVF mandate.

Study of Mandated Health Insurance Services: A Comparative Evaluation

Report Prepared by Mercer Human Resource Consulting

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Introduction

This report contains four sections. The first section evaluates the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of premiums for the individual and group health insurance market. The second section assesses the degree to which existing mandated health insurance services are covered in self-funded plans. The third section applies the voluntary compliance from the second section to estimate the marginal cost of the mandates. The last section compares the mandated health insurance services required in Maryland with those required in Delaware, the District of Columbia, Pennsylvania, and Virginia.

This report uses various sources of information including a survey of health plans and a survey of collective bargaining agents. Mercer surveyed five prominent health plans in the Maryland market, all of which participate in the Maryland small-group market. The health plans were surveyed on their coverage practices in the self-funded group market in Maryland. The surveys produced data for an overview of practices and coverage in the Maryland marketplace.

Mercer's analysis incorporates data from our proprietary databases, which include financial information on indemnity and managed care plans. These databases were developed by purchasing data from other sources and through several comprehensive surveys. We update the databases regularly.

Another major resource for this report was the Internet. Through searches on the Internet, we collected published articles and information on the benefit mandates.

Full Cost of Current Mandates

Section 15-1502 of the Maryland Insurance Article requires an assessment of the full cost of each existing mandated service as a percentage of the State's average annual wage and of premiums for the individual and group health insurance market. The mandates included in this requirement are the 40 mandates defined in Sections 15-801 through 15-840 of the Insurance Article. Under group insurance, we excluded the small group CSHBP, because the CSHBP is exempt from mandates unless the Commission adopts the mandate for the CSHBP.

The full cost of the current mandates is summarized in the following table.

Full Cost of Current Mandates

Mandate	Section	Full Cost		
		Percentage of Premium*	Percentage of Wage	
			Individual	Group
Alzheimer's	15-801	0.0%	0.0%	0.0%
Mental illness; drug & alcohol abuse	15-802	4.9%	1.1%	0.8%
Blood products	15-803	0.5%	0.1%	0.1%
Off-label use of drugs	15-804	0.3%	0.1%	0.0%
Pharmaceutical products	15-805	0.1%	0.0%	0.0%
Choice of pharmacy	15-806**	0.0%	0.0%	0.0%
Medical foods & modified food products	15-807	0.0%	0.0%	0.0%
Home health care	15-808	0.4%	0.1%	0.1%
Hospice care	15-809	0.0%	0.0%	0.0%
In vitro fertilization	15-810	0.8%	0.2%	0.1%
Hospitalization benefits for childbirth	15-811	2.1%	0.4%	0.3%
Length of stay for mothers of newborn	15-812	1.0%	0.2%	0.2%
Disability due to pregnancy or childbirth	15-813	0.0%	0.0%	0.0%
Mammograms	15-814	0.5%	0.1%	0.1%
Reconstructive breast surgery	15-815	0.1%	0.0%	0.0%
Routine gynecological care	15-816	0.0%	0.0%	0.0%
Child wellness	15-817	0.7%	0.2%	0.1%
Treatment of cleft lip and cleft palate	15-818	0.2%	0.1%	0.0%
OP services and second opinions	15-819	0.0%	0.0%	0.0%
Prosthetic devices & orthopedic braces	15-820**	0.0%	0.0%	0.0%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	0.3%	0.1%	0.0%
Diabetes equipment, supplies, & self management training	15-822	0.6%	0.1%	0.1%
Osteoporosis treatment	15-823	0.5%	0.1%	0.1%
Maintenance drugs	15-824	0.1%	0.0%	0.0%
Detection of prostate cancer	15-825	0.7%	0.2%	0.1%
Contraceptives	15-826	0.2%	0.0%	0.0%
Clinical trials under specific conditions	15-827	0.2%	0.0%	0.0%
General anesthesia for dental care under specified conditions	15-828	0.0%	0.0%	0.0%
Chlamydia screening	15-829	0.1%	0.0%	0.0%
Referrals to specialists	15-830	0.0%	0.0%	0.0%
Prescription drugs and devices	15-831	0.0%	0.0%	0.0%
Length of stay for mastectomies	15-832	0.0%	0.0%	0.0%
Extension of benefits	15-833	0.0%	0.0%	0.0%
Prosthesis following mastectomy	15-834	0.0%	0.0%	0.0%
Habilitative services for children	15-835	0.0%	0.0%	0.0%
Wigs for hair loss due to chemotherapy	15-836	0.0%	0.0%	0.0%
Colorectal cancer screening	15-837	0.1%	0.0%	0.0%
Hearing aids for a minor child	15-838	0.1%	0.0%	0.0%
Treatment of morbid obesity	15-839	0.5%	0.1%	0.1%
Residential crisis services	15-840	0.0%	0.0%	0.0%
Total		**15.2%**	**3.3%**	**2.4%**

** Applies to both group and individual policies*

*** Value excluded because mandate applies only to non-profit health service plans*

Note: Totals may not add due to rounding

Full Cost of Current Mandates

When expressing the cost of the mandates as a percentage of the average annual wage, we did not segregate the wage by type of contract; therefore, we used the same wage base for all types of contracts. The average annual wage in 2002 was $39,360, according to statistics from the Maryland Department of Labor, Licensing and Regulation (DLLR).

On a full cost basis, the most expensive mandates are:

- Mental illness and substance abuse as covered under Section 15-802 with a cost equal to 4.9% of premium.
- Hospitalization benefits for childbirth and length of stay for mothers of newborn under Sections 15-811 and 15-812 with a full cost equal to 3.1% of premium.

Voluntary Compliance in the Self-Funded Market

Another requirement under Section 15-1502 of the Maryland Insurance Article is to assess the degree to which existing mandated services are covered in self-funded plans. Through ERISA, employers who self-fund their health benefit plan are exempt from the mandate requirements. The section examines if there are mandates which self-funded plans typically exclude. In order to address this question, Mercer used a custom survey for the MHCC to compare the benefits of an insured plan to self-funded benefits offered by large employers. The survey addressed the voluntary benefit mandate compliance of self-funded plans.

To get a reliable sample, we surveyed the primary carriers that administer the health benefits for self-funded plans in Maryland. This included Aetna, CareFirst, Cigna, MAMSI/OCI, and United HealthCare. The survey defined the Maryland health insurance mandates and asked the health plan administrators to report the rate of voluntary compliance and the typical level of benefits. While the administrators were not legally required to respond to the survey, they replied to almost all the questions. We followed up on any missing or incomplete responses. However, while asked, only one carrier was able to report on how many self-funded lives they cover in Maryland.

To check the reasonableness of the administrators' responses, we compared their answers to the benefit plans of eight of our largest Maryland based clients with self-funded plans. These eight employers cover over 100,000 employees or almost 300,000 people when including dependents. Our comparison confirmed the reasonableness of the administrators' answers.

As a third source of benefit information, we used Mercer's 2002 National Survey of Employer-Sponsored Health Plans. This survey contains data from 2,889 employers on the scope of coverage but does not focus on the Maryland health insurance mandates. This survey did allow for a secondary reasonability check of the administrator's answers on some health benefits such as mental health and substance abuse benefits.

We use the following rankings of voluntary compliance by mandate:

- All comply – all employers with self-funded plans provide benefits that comply fully with the mandate requirement
- Almost all comply – a small percentage of employers with self-funded plans provide benefits that do not comply fully with the mandate requirement
- Most comply – significantly more than half but not all employers with self-funded plans provide benefits that comply fully with the mandate requirement
- Half comply – about 50% of employers with self-funded plans provide benefits that comply fully with the mandate requirement
- Some comply – significantly less than half of employers with self-funded plans provide benefits that comply fully with the mandate requirement
- No compliance – no employers with self-funded plans provide benefits that comply fully with the mandate requirement.

The following chart shows the compliance rate by mandate:

Voluntary Compliance in the Self-Funded Market

Subsection	Mandate Description	Compliance Rate
15-801	Benefits for Alzheimer's disease and care of elderly individuals	Half
15-802	Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	Half
15-803	Payments for blood products	Most
15-804	Coverage for off-label use of drugs	Most
15-805	Reimbursement for pharmaceutical products	Half
15-806	Choice of pharmacy for filling prescriptions	Most
15-807	Coverage for medical foods and modified food products	Almost All
15-808	Benefits for home health care	All
15-809	Benefits for hospice care	All
15-810	Benefits for in vitro fertilization (IVF)	Some
15-811	Hospitalization benefits for childbirth	All
15-812	Impatient hospitalization coverage for mothers and newborn children	All
15-813	Benefits for disability caused by pregnancy or childbirth	Most
15-814	Coverage for mammograms	Almost All
15-815	Coverage for reconstructive breast surgery	Almost All
15-816	Benefits for routine gynecological care	Almost All
15-817	Coverage for child wellness services	Almost All
15-818	Benefits for treatment of cleft lip and cleft palate	All
15-819	Coverage for outpatient services and second opinions	All
15-820	Benefits for prosthetic devices and orthopedic braces	Almost All
15-821	Diagnostic and surgical procedures for bones of face, neck and head	Almost All
15-822	Coverage for diabetes equipment, supplies, and self-management training	All
15-823	Coverage for osteoporosis prevention and treatment	Almost All
15-824	Coverage for maintenance drugs	Most
15-825	Coverage for detection of prostate cancer	Almost All
15-826	Coverage for contraceptive drugs and devices	Most
15-827	Coverage for patient cost for clinical trials	Almost All
15-828	Coverage for general anesthesia for dental care under specified conditions	Almost All
15-829	Coverage for detection of Chlamydia	Almost All
15-830	Referrals to specialists	All
15-831	Coverage of prescription drugs and devices	Most
15-832	Coverage for mastectomies	All
15-833	Extension of benefits	Most
15-834	Coverage for prostheses	Almost All
15-835	Coverage for habilitative services for children under 19 years of age	Most
15-836	Hair prosthesis	Most
15-837	Colorectal cancer screening coverage	Most
15-838	Hearing aid coverage for a minor child	Most
15-839	Coverage for treatment of morbid obesity	Most
15-840	Coverage for medically necessary residential crisis services	Most

Voluntary Compliance in the Self-Funded Market

The voluntary compliance rate shows the difference between the responsibility of mandates put on employers with insured plans and the responsibility of mandates taken on voluntarily by self-funded plans. Overall, self-funded plans voluntarily cover 90% of the cost of mandated services.

Of the Maryland mandates, the most expensive group insurance mandate based on full cost is for mental health and substance abuse benefits (Section 15-802), at almost 5% of premium. While about half of the employers with self-funded plans cover mental health and substance abuse benefits at or above the level required by the mandate, the other half cover the benefit at a lesser level.

The next most expensive mandate based on full cost is hospitalization for childbirth (Section 15-811), at over 3% of premium when including the mandate on the minimum length of stay (Section 15-812). Our survey shows that all employers with self-funded plans cover the benefit as mandated.

The only mandate that the vast majority of employers with self-funded plans do not cover is benefits for in vitro fertilization (Section 15-810). The full cost of this mandate is almost 1% of premium for insured plans. The 2002 Mercer National Survey of Employer-Sponsored Health Plans shows that, nationally, only about 13% of employers cover IVF.

Marginal Cost of Current Mandates

The financial cost of mandated health insurance services could be defined either as the full cost of the service or as the marginal or additional cost of the mandate. The marginal cost equals the full cost of the service minus the value of the services that would be covered in the absence of the mandate. For example, the full cost for requiring coverage of hospitalization for maternity equals the assumed number of maternity cases times the hospital cost per case. The vast majority of contracts would include coverage of maternity cases that satisfies the mandate requirements even without the mandate; therefore, the marginal cost equals the assumed number of cases that would not be covered without the mandate times the hospital cost per case. This section shows estimates for the marginal cost.

In the previous section, we looked at the voluntary compliance rate for self-funded plans. We assume that in the absence of mandates, insurance contract holders would request the same level of coverage as the level provided by self-funded plans and that carriers would be willing to offer that level of coverage. In a competitive work environment, coverage in self-funded plans becomes the de facto coverage in other markets with or without mandates as fully-insured employers must provide similar benefits as they compete for the same workers. Under this assumption, the marginal cost of the mandate equals the portion of mandated coverage not picked up by self-funded plans.

The following table shows the marginal cost of each of the 40 existing mandated services as a percentage of the State's average annual wage and of premiums for the individual and group health insurance market.

Marginal Cost of Current Mandates

Mandate	Section	Expected Portion of Cost Covered Without Mandate	Marginal Cost		
			Percentage of Premium*	Percentage of Wage	
				Individual	Group
Alzheimer's	15-801	50%	0.0%	0.0%	0.0%
Mental illness; drug & alcohol abuse	15-802	90%	0.5%	0.1%	0.1%
Blood products	15-803	99%	0.0%	0.0%	0.0%
Off-label use of drugs	15-804	85%	0.0%	0.0%	0.0%
Pharmaceutical products	15-805	50%	0.1%	0.0%	0.0%
Choice of pharmacy	15-806**	85%	0.0%	0.0%	0.0%
Medical foods & modified food products	15-807	98%	0.0%	0.0%	0.0%
Home health care	15-808	100%	0.0%	0.0%	0.0%
Hospice care	15-809	100%	0.0%	0.0%	0.0%
In vitro fertilization	15-810	15%	0.7%	0.1%	0.1%
Hospitalization benefits for childbirth	15-811	100%	0.0%	0.0%	0.0%
Length of stay for mothers of newborn	15-812	100%	0.0%	0.0%	0.0%
Disability due to pregnancy or childbirth	15-813	85%	0.0%	0.0%	0.0%
Mammograms	15-814	98%	0.0%	0.0%	0.0%
Reconstructive breast surgery	15-815	99%	0.0%	0.0%	0.0%
Routine gynecological care	15-816	98%	0.0%	0.0%	0.0%
Child wellness	15-817	99%	0.0%	0.0%	0.0%
Treatment of cleft lip and cleft palate	15-818	100%	0.0%	0.0%	0.0%
Out-patient services and second opinions	15-819	100%	0.0%	0.0%	0.0%
Prosthetic devices & orthopedic braces	15-820**	99%	0.0%	0.0%	0.0%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	99%	0.0%	0.0%	0.0%
Diabetes equipment, supplies, & self management training	15-822	100%	0.0%	0.0%	0.0%
Osteoporosis treatment	15-823	95%	0.0%	0.0%	0.0%
Maintenance drugs	15-824	95%	0.0%	0.0%	0.0%
Detection of prostate cancer	15-825	99%	0.0%	0.0%	0.0%
Contraceptives	15-826	85%	0.0%	0.0%	0.0%
Clinical trials under specific conditions	15-827	90%	0.0%	0.0%	0.0%
General anesthesia for dental care under specified conditions	15-828	90%	0.0%	0.0%	0.0%
Chlamydia screening	15-829	99%	0.0%	0.0%	0.0%
Referrals to specialists	15-830	100%	0.0%	0.0%	0.0%
Prescription drugs and devices	15-831	75%	0.0%	0.0%	0.0%
Length of stay for mastectomies	15-832	100%	0.0%	0.0%	0.0%
Extension of benefits	15-833	95%	0.0%	0.0%	0.0%
Prosthesis following mastectomy	15-834	99%	0.0%	0.0%	0.0%
Habilitative services for children	15-835	70%	0.0%	0.0%	0.0%
Wigs for hair loss due to chemotherapy	15-836	85%	0.0%	0.0%	0.0%
Colorectal cancer screening	15-837	90%	0.0%	0.0%	0.0%
Hearing aids for a minor child	15-838	75%	0.0%	0.0%	0.0%
Treatment of morbid obesity	15-839	75%	0.1%	0.0%	0.0%
Residential crisis services	15-840	95%	0.0%	0.0%	0.0%
Total		**90%**	**1.6%**	**0.3%**	**0.2%**

* *Applies to both group and individual policies*

** *Value excluded because mandate applies only to non-profit health service plans*

Note: Totals may not add due to rounding

Marginal Cost of Current Mandates

On a marginal cost basis, the most expensive mandate is for IVF, under Section 15-810, with a marginal cost equal to 0.7% of premium.

The next most expensive mandate on a marginal cost basis is mental illness and substance abuse, under Section 15-802, with a marginal cost equal to 0.5% of premium. The actual cost will vary by plan and will depend on how they manage mental health benefits. Some plans carve out these services to a specialty vendor who will manage the benefits. Under benefit management, there is a reduced probability of a policyholder ever utilizing the maximum level of the benefit and, therefore, the marginal cost would be less.

Comparison to Other States

Section 15-1502 of the Maryland Insurance Article requires a comparison of mandated services required by Maryland with those required in Delaware, the District of Columbia, Pennsylvania, and Virginia, including the:

- Number of mandated health insurance services
- Type of mandated health insurance services
- Level and extent of coverage for each mandated health insurance service
- Financial impact of differences in levels of coverage for each mandated health insurance service.

This report focuses on benefit requirements included under Subtitle 8 of Title 15 of Maryland's Insurance Law. Mercer compared these mandates to mandates required in the following states using the corresponding sources:

State	Insurance Code
Maryland	Maryland Code Annotated
Delaware	Delaware Code
District of Columbia	District of Columbia Code
Pennsylvania	Pennsylvania Unconsolidated Statutes
Virginia	Virginia Code Annotated & Virginia Administrative Code

While these comparative states may have mandates that address the same health services, different states may have significantly different criteria related to the mandate. A short description of each state's mandate is included in Exhibit 1. For the 40 Maryland mandates covered in this report, the following table summarizes how many are mandated in some form by Delaware, the District of Columbia, Pennsylvania, and Virginia.

State	Number of Maryland Mandated Benefits Required in Neighboring States
Delaware	**16**
District of Columbia	**11**
Maryland	**40**
Pennsylvania	**15**
Virginia	**22**

Comparison to Other States

This would indicate that, given the number of benefits mandated, Maryland has the highest burden; however, this does not take into account the relative cost of the mandates.

To understand the difference in the financial burden, we look at the estimated financial impact if Maryland changed its existing mandate to match the mandate of one of these other states. Looking at just the 40 benefits mandated in Maryland, the following table shows the estimated full and marginal costs for each state.

MD Mandate	Value Relative to MD Mandate				Premium Impact to Revise Mandate to Match Other State							
					Full Cost				Marginal Cost			
	DE	DC	PA	VA	DE	DC	PA	VA	DE	DC	PA	VA
15-801	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-802	110%	100%	80%	60%	0.5%	0.0%	-1.0%	-2.0%	0.0%	0.0%	-0.1%	-0.2%
15-803	0%	0%	0%	0%	-0.5%	-0.5%	-0.5%	-0.5%	0.0%	0.0%	0.0%	0.0%
15-804	0%	0%	0%	25%	-0.3%	-0.3%	-0.3%	-0.2%	0.0%	0.0%	0.0%	0.0%
15-805	100%	0%	0%	0%	0.0%	-0.1%	-0.1%	-0.1%	0.0%	-0.1%	-0.1%	-0.1%
15-806	100%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-807	0%	0%	50%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-808	0%	0%	0%	0%	-0.4%	-0.4%	-0.4%	-0.4%	0.0%	0.0%	0.0%	0.0%
15-809	0%	0%	0%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-810	0%	0%	0%	0%	-0.8%	-0.8%	-0.8%	-0.8%	-0.7%	-0.7%	-0.7%	-0.7%
15-811	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-812	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-813	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-814	100%	110%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-815	95%	120%	95%	50%	0.0%	0.0%	0.0%	-0.1%	0.0%	0.0%	0.0%	0.0%
15-816	0%	100%	100%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-817	40%	95%	40%	60%	-0.4%	0.0%	-0.4%	-0.3%	0.0%	0.0%	0.0%	0.0%
15-818	40%	0%	100%	100%	-0.1%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-819	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-820	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-821	0%	0%	0%	100%	-0.3%	-0.3%	-0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
15-822	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-823	0%	0%	0%	0%	-0.5%	-0.5%	-0.5%	-0.5%	0.0%	0.0%	0.0%	0.0%
15-824	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%
15-825	75%	100%	0%	90%	-0.2%	0.0%	-0.7%	-0.1%	0.0%	0.0%	0.0%	0.0%
15-826	100%	0%	0%	100%	0.0%	-0.2%	-0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
15-827	100%	0%	0%	70%	0.0%	-0.2%	-0.2%	-0.1%	0.0%	0.0%	0.0%	0.0%
15-828	0%	0%	0%	85%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-829	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%
15-830	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-831	0%	0%	0%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-832	0%	0%	90%	120%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-833	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-834	0%	0%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-835	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-836	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-837	100%	100%	0%	100%	0.0%	0.0%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
15-838	0%	0%	0%	0%	-0.1%	-0.1%	-0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%
15-839	0%	0%	0%	100%	-0.5%	-0.5%	-0.5%	0.0%	-0.1%	-0.1%	-0.1%	0.0%
15-840	0%	0%	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**73%**	**70%**	**57%**	**64%**	**-4.1%**	**-4.5%**	**-6.5%**	**-5.4%**	**-0.9%**	**-1.1%**	**-1.2%**	**-1.1%**

Note: Totals may not add due to rounding

Comparison to Other States

When applying the differences, there are both increases and reductions in the level of the mandates. Overall, the value of the reductions exceeds the value of the increases in each state.

On a full cost basis, the majority of the reductions to premiums come from the following mandates:

- Mental illness and substance abuse (§15-802) in PA and VA (1.0% - 2.0%)
- Payment for blood products (§15-803) in DE, DC, PA, and VA (0.5%)
- Coverage for off-label use of drugs (§15-804) in DE, DC, PA, and VA (0.2% - 0.3%)
- Home health care (§15-808) in DE, DC, PA, and VA (0.4%)
- In vitro fertilization (§15-810) in DE, DC, PA, and VA (0.8%)
- Child wellness services (§15-817) in DE, PA, and VA (0.3% - 0.4%)
- Diagnostic and surgical procedures for bones of face, neck and head (§15-821) in DE, DC, and PA (0.3%)
- Osteoporosis prevention and treatment (§15-823) in DE, DC, PA, and VA (0.5%)
- Prostate cancer screening (§15-825) in DE and PA (0.2% - 0.7%)
- Morbid obesity treatment (§15-839) in DE, DC, and PA (0.5%).

On a full cost basis for these 40 Maryland mandates, the other states have a lower financial burden. Based on a percentage of premium, the difference ranges from 4.1% of premium lower in Delaware to 6.5% lower in Pennsylvania.

Also, on a marginal cost basis for these 40 Maryland mandates, the other states have a lower financial burden, but the picture is significantly different. Based on a percentage of premium, the difference ranges from 0.9% of premium lower in Delaware to 1.2% lower in Pennsylvania. The following mandates contribute to the financial difference:

- Mental illness and substance abuse (§15-802) in PA and VA
- Pharmaceutical products (§15-805) in DC, PA, and VA
- In vitro fertilization (§15-810) in DE, DC, PA, and VA
- Morbid obesity treatment (§15-839) in DE, DC, and PA.

Of these four mandates, IVF stands out with a 0.7% of premium difference under the marginal cost basis. While all these mandates were passed with the intention of improving access to medically necessary care, many self-funded plans do not view IVF as medically necessary; therefore, the marginal cost is almost as high as the full cost. The other three mandates do not have a significantly higher marginal cost in Maryland, and it can be argued that these benefits will actually reduce future health care costs.

Next, we look at the financial impact of adopting either the most generous or least generous mandate in the surrounding states. The impact is summarized in the following table:

Comparison to Other States

MD Mandate	Value Relative to MD Mandate		Premium Impact to Revise Mandate to Match Other State			
			Full Cost		Marginal Cost	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
15-801	0%	0%	0.0%	0.0%	0.0%	0.0%
15-802	60%	110%	-2.0%	0.5%	-0.2%	0.0%
15-803	0%	0%	-0.5%	-0.5%	0.0%	0.0%
15-804	0%	25%	-0.3%	-0.2%	0.0%	0.0%
15-805	0%	100%	-0.1%	0.0%	-0.1%	0.0%
15-806	0%	100%	0.0%	0.0%	0.0%	0.0%
15-807	0%	50%	0.0%	0.0%	0.0%	0.0%
15-808	0%	0%	-0.4%	-0.4%	0.0%	0.0%
15-809	0%	100%	0.0%	0.0%	0.0%	0.0%
15-810	0%	0%	-0.8%	-0.8%	-0.7%	-0.7%
15-811	100%	100%	0.0%	0.0%	0.0%	0.0%
15-812	100%	100%	0.0%	0.0%	0.0%	0.0%
15-813	0%	0%	0.0%	0.0%	0.0%	0.0%
15-814	100%	110%	0.0%	0.0%	0.0%	0.0%
15-815	50%	120%	-0.1%	0.0%	0.0%	0.0%
15-816	0%	100%	0.0%	0.0%	0.0%	0.0%
15-817	40%	95%	-0.4%	0.0%	0.0%	0.0%
15-818	0%	100%	-0.2%	0.0%	0.0%	0.0%
15-819	0%	0%	0.0%	0.0%	0.0%	0.0%
15-820	0%	0%	0.0%	0.0%	0.0%	0.0%
15-821	0%	100%	-0.3%	0.0%	0.0%	0.0%
15-822	100%	100%	0.0%	0.0%	0.0%	0.0%
15-823	0%	0%	-0.5%	-0.5%	0.0%	0.0%
15-824	0%	0%	-0.1%	-0.1%	0.0%	0.0%
15-825	0%	100%	-0.7%	0.0%	0.0%	0.0%
15-826	0%	100%	-0.2%	0.0%	0.0%	0.0%
15-827	0%	100%	-0.2%	0.0%	0.0%	0.0%
15-828	0%	85%	0.0%	0.0%	0.0%	0.0%
15-829	0%	0%	-0.1%	-0.1%	0.0%	0.0%
15-830	0%	0%	0.0%	0.0%	0.0%	0.0%
15-831	0%	100%	0.0%	0.0%	0.0%	0.0%
15-832	0%	120%	0.0%	0.0%	0.0%	0.0%
15-833	0%	0%	0.0%	0.0%	0.0%	0.0%
15-834	0%	100%	0.0%	0.0%	0.0%	0.0%
15-835	0%	0%	0.0%	0.0%	0.0%	0.0%
15-836	0%	0%	0.0%	0.0%	0.0%	0.0%
15-837	0%	100%	-0.1%	0.0%	0.0%	0.0%
15-838	0%	0%	-0.1%	-0.1%	0.0%	0.0%
15-839	0%	100%	-0.5%	0.0%	-0.1%	0.0%
15-840	0%	0%	0.0%	0.0%	0.0%	0.0%
Total			**-7.8%**	**-2.3%**	**-1.3%**	**-0.7%**

Note: Totals may not add due to rounding

Comparison to Other States

This table shows that by going to the lowest level, which may be no mandate, for each of the 40 benefits, the full cost would be reduced by 7.8% of premium compared to Maryland's current level of 15.2% of premium, therefore, the full cost would be 7.4% of premium. Similarly, the marginal cost of current mandates would be reduced by 1.3% of premium and drop from 1.6% of premium to 0.3% of premium.

The following mandates have a full cost of 0.5% of premium or greater when the minimum level covered in another state is considered:

- Mental illness and substance abuse
- Payment for blood products
- In vitro fertilization
- Osteoporosis prevention and treatment
- Prostate cancer screening
- Morbid obesity treatment.

It should be noted that none of the surrounding states in this study have mandates similar to the following 13 Maryland mandates:

Maryland Mandate	Cost as a Percentage of Premium	
	Full	Marginal
15-801: Alzheimer's disease and care of elderly individuals	0.0%	0.0%
15-810: In vitro fertilization	0.8%	0.7%
15-813: Disability caused by pregnancy or childbirth	0.0%	0.0%
15-819: Outpatient services and second opinions	0.0%	0.0%
15-820: Prosthetic devices and orthopedic braces	0.0%	0.0%
15-823: Osteoporosis prevention and treatment	0.5%	0.0%
15-824: Maintenance prescription drugs	0.1%	0.0%
15-829: Chlamydia screening	0.1%	0.0%
15-833: Extension of benefits	0.0%	0.0%
15-835: Habilitative services for children	0.0%	0.0%
15-836: Hair prosthesis	0.0%	0.0%
15-838: Hearing aid coverage for children	0.1%	0.0%
15-840: Residential crisis services	0.0%	0.0%
Total	**1.6%**	**0.7%**

By going to the highest level outside of Maryland, which still may be no mandate, for each of the 40 benefits, the full cost would be reduced by 2.3% of premium. Therefore, the full cost would be 12.9% of premium instead of the current 15.2%. Similarly, the marginal cost of current mandates would be reduced by 0.7% of premium and drop to 0.9% of premium instead of the current 1.6%. This does NOT include benefit mandates required outside of Maryland if a similar mandate is not required in Maryland.

Comparison to Other States

Following is a summary of mandated benefits required outside of Maryland where a similar mandate is not required in Maryland:

Delaware:

Mandate	Description	Statutory Citation
Ovarian Cancer	Ovarian cancer screening (CA-125) subsequent to treatment must be covered for enrollees residing or having their principal place of employment in Delaware.	18-3555
Pap smears	Mandatory annual benefit for Pap smears for all females age 18 and over.	18-3559B; 18-3552

District of Columbia:

Mandate	Description	Statutory Citation
AIDS	Coverage required; insurer may not limit coverage or impose a deductible or coinsurance provision related to the care of AIDS or related diseases unless it applies to all covered diseases.	31-1603
Pap smears	Mandatory coverage for Pap smear annually and when medically necessary. Coverage may not be subject to an annual deductible or coinsurance.	35-2402

Pennsylvania:

Mandate	Description	Statutory Citation
Pap smears	Required coverage for an annual gynecological examination and routine Pap smears.	40 P.S. s 1574

Virginia:

Mandate	Description	Statutory Citation
AIDS	Insurers may not exclude or limit coverage or treatment of HIV infection or AIDS or related complications.	38.2-3401; 14 VAC 5-180-60
Hemophilia	Coverage required for the treatment of hemophilia and other congenital bleeding disorders; must include home treatment coverage.	38.2-3418.3
Hospital Stay for Hysterectomy	Mandatory coverage for hysterectomy with a 23 hour post-op stay.	38.2-3418.9
Lymphedema	Mandatory coverage for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema.	38.2-3418.14
Pap smears	Coverage required for annual Pap smears.	38.2-3418.1:2

Comparison to Other States

Adding these additional mandates to the Maryland mandates covered in other states, the neighboring states come somewhat closer to the 40 mandates required in Maryland. The following table summarizes the number of mandates in each state:

State	Total Number of Mandated Benefits
Delaware	18
District of Columbia	13
Maryland	40
Pennsylvania	16
Virginia	27

Six mandates are required by one or more neighboring states but are not required in Maryland. **If Maryland would adopt these additional mandates, it would increase the full cost of mandates by up to 3.3% of premium.** Mercer's survey of carriers in the Maryland market shows that insured health plans in Maryland already comply with these mandates with the exception of waiving the deductible and coinsurance on Pap smears, as required under the District of Columbia mandate. As a result, there is no marginal cost associated with these six mandates. The potential cost of these six additional mandates in their respective states is summarized in the following table:

Mandate Not Required in Maryland	Premium Impact to Add Mandate to Match Other State											
	Full Cost				Marginal Cost				Full Cost		Marginal Cost	
	DE	DC	PA	VA	DE	DC	PA	VA	Minimum	Maximum	Minimum	Maximum
AIDS treatment	-	1.9%	-	1.9%	-	-	-	-	0.0%	1.9%	0.0%	0.0%
Lymphedema treatment	-	-	-	0.1%	-	-	-	-	0.0%	0.1%	0.0%	0.0%
Hemophilia treatment	-	-	-	0.3%	-	-	-	-	0.0%	0.3%	0.0%	0.0%
Hysterectomy post-op stay	-	-	-	0.0%	-	-	-	-	0.0%	0.0%	0.0%	0.0%
Ovarian cancer screening	0.1%	-	-	-	-	-	-	-	0.0%	0.1%	0.0%	0.0%
Pap smears/gynecological exams	0.3%	0.4%	0.9%	0.3%	-	0.0%	-	-	0.3%	0.9%	0.0%	0.0%
Total	**0.4%**	**2.3%**	**0.9%**	**2.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.3%**	**3.3%**	**0.0%**	**0.0%**

When combining the mandates required in Maryland and these six additional mandates, the difference in the full cost of mandates between Maryland and its neighboring states decreases. The marginal cost difference remains about the same. The following table shows the cost difference expressed as a percentage of premium:

Comparison to Other States

Mandate	Premium Impact to Revise Mandate to Match Other State							
	Full Cost				Marginal Cost			
	DE	DC	PA	VA	DE	DC	PA	VA
Required in MD	-4.1%	-4.5%	-6.5%	-5.4%	-0.9%	-1.1%	-1.2%	-1.1%
Not required in MD	0.4%	2.3%	0.9%	2.6%	0.0%	0.0%	0.0%	0.0%
Total	**-3.7%**	**-2.2%**	**-5.6%**	**-2.8%**	**-0.9%**	**-1.0%**	**-1.2%**	**-1.1%**

Note: Totals may not add due to rounding

After including these six additional mandates, on a full cost basis for all mandates, the other states still have a lower financial burden. The difference ranges from 2.2% of premium lower in the District of Columbia to 5.6% lower in Pennsylvania.

Also, on a marginal cost basis for all mandates, the other states still have a lower financial burden, but the difference is much lower than under the full cost basis. The difference ranges from 0.9% of premium lower in Delaware to 1.2% lower in Pennsylvania.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
801	15-801: Benefits for Alzheimer's disease and care of elderly individuals	Health insurers must offer the option of including benefits for the expenses arising from the care of victims of Alzheimer's disease and the care of the elderly to all group purchasers.				
802	Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	Mandatory coverage on the same terms as physical illness; minimum 60 days partial hospitalization; 80% coverage for first 5 visits; 65% coverage of 6-30 visits; 50% coverage for visits beyond 30. Lifetime limits same as physical illness.	18-3343: Mandatory coverage for drug and alcohol dependencies. Terms of the coverage cannot place a greater financial burden on an insured than for covered services of any other illness or disease. 18-3566: Mandatory coverage for serious mental illnesses. Terms of the coverage cannot place a greater financial burden on an insured than for covered services of any other illness or disease.	31-3102; 31-3103: Alcohol/ Substance Abuse - Minimum yearly inpatient coverage of 28 days, plus 12 days for detoxification; 30 days minimum outpatient visits. 35-2302; 35-2304; 35-2305: Mental Health - Mandatory coverage of 45 days inpatient. Outpatient coverage must be at least 75% for the first 40 visits during the year; 60% after that. Lifetime maximum of the greater of $80,000 or 1/3 the lifetime max for physical illness.	40 P.S. 908-3; 908-4; 908-5: Alcohol/ Substance Abuse - Mandatory coverage of 7 days per inpatient admission, 30 days non-hospital residential treatment coverage, and 30 days minimum outpatient visits. 40 P.S. 764q: Mental Health - Mandatory coverage of 30 days inpatient coverage and 60 days minimum outpatient visits. Lifetime maximum cannot be less than lifetime coverage for physical illness.	38.2-3412.1: Alcohol/ Substance Abuse - Minimum yearly inpatient coverage of 20 days for adults and 25 days for children; 20 days minimum outpatient visits. Mental Health - Minimum yearly inpatient coverage of 20 days for adults and 25 days for children; 20 days minimum outpatient visits. Lifetime maximum cannot be more restrictive than that for physical illness; coinsurance cannot exceed 50% for outpatient visits.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
803	Payments for blood products	Health insurers may not exclude payments for blood products except whole blood or concentrated red blood cells				38.2-3418.3: blood products for home treatment of hemophilia must be covered
804	Coverage for off-label use of drugs	Requires coverage for approved off-label drugs				38.2-3407.5; 38.2-3407.6: Mandatory coverage of off-label cancer drugs and excess dosages of drugs to relieve cancer pain.
805	Reimbursement for pharmaceutical products	Subject policies cannot establish varied reimbursement based on the type prescriber and cannot vary copayments based on community pharmacy vs. mail order	18 s 7303: Insurers and HMOs cannot impose on a beneficiary any co-payment or condition that is not equally imposed with all contracting pharmacy providers the beneficiary may utilize. Nor can they require an enrollee to prescription drugs exclusively through a mail-order pharmacy.			
806	Choice of pharmacy for filling prescriptions	The non-profit health service plan shall allow the member to fill prescriptions at the pharmacy of choice	18 s 7303: Enrollees must be able to select the pharmacy of their choice as long as the pharmacy agrees to participate in the plan according to its terms			

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
807	Coverage for medical foods and modified food products	Mandatory coverage of medically necessary, low protein modified medical food products.			40 P.S. 3904: Mandatory coverage for the cost of medically necessary nutritional supplements and formulas in the treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.	
808	Benefits for home health care	Mandatory home health care coverage for enrollees who would have otherwise required institutionalization up to 40 visits per year for up to 4 hours per visit.			40 P.S. s 764d: Mandatory coverage for a medically necessary home health care visit within 48 hours after a mastectomy. 40 P.S. s 1583: Mandatory and visit within 48 hours after discharge for childbirth when discharge occurs prior to 48-96 guidelines.	
809	Benefits for hospice care	Health insurers must offer individuals and groups benefits for hospice care services				38.2-3418.11: Coverage mandatory for hospice services including psychological , psychosocial, and other health services.
810	Benefits for in vitro fertilization (IVF)	If pregnancy is covered, all outpatient procedures associated with in vitro fertilization must be covered. Exempts religious organizations.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
811	Hospitalization benefits for childbirth	Every insurance policy that provides benefits for normal pregnancy must provide hospitalization benefits to the same extent as that for any covered illness	See section 812	See section 812	See section 812	See section 812
812	Inpatient hospitalization coverage for mothers and newborn children	If pregnancy covered, hospitalization for childbirth and postpartum stay of 48 to 96 hours must also be covered.	18-3553: Maternity coverage is not required. If it is covered, post delivery stay must meet federal standards. Services by a licensed certified nurse midwife must be covered.	35-1102.1: Plans that provide maternity coverage must cover inpatient postpartum stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Cesarean delivery.	40 P.S. 1583; 3002: If maternity care is covered, post delivery inpatient care must be covered for 48-96 hours. Must also cover services by a licensed certified nurse midwife. Mandatory coverage for one home health care visit within 48 hours after discharge for childbirth when discharge occurs prior to 48-96 guidelines.	38.2-3414.2; 38.2-3418: Maternity coverage not required except in the case of rape or incest, but must be an employer option. If it is covered, post delivery stay must be covered for 48-96 hours.
813	Benefits for disability caused by pregnancy or childbirth	Insurers must offer to groups purchasing a temporary disability policy the option of extending these benefits to temporary disabilities caused by pregnancy or childbirth				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
814	Coverage for mammograms	All hospital and major medical insurance policies must include coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50	18-3552: Mandatory coverage for one mammogram for women age 35 or older, every 1 to 2 years for women age 40 to 50, every year for women age 50 and over and for any woman who is at high risk for breast cancer.	31-2902: Mandated baseline and annual mammogram for women. Coverage may not be subject to an annual or coinsurance deductible.	40 P.S. 764c: Required coverage for all costs associated with a mammogram every year for women age 40 or older or when medically necessary.	38.2-3418.1: Coverage required includes one mammogram for women ages 35-39, one every other year for those 40-49, and one annually for women 50 and older.
815	Coverage for reconstructive breast surgery	Requires carriers to provide coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts	18-3559: Mandatory benefits for reconstructive surgery following mastectomies including surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses.	2000 Act 13-541: If mastectomies are covered, reconstructive surgery, including surgery of the healthy breast to produce a symmetrical appearance and prosthetic devices must also be covered.	40 P.S. 764d: If mastectomies are covered, coverage is also required for prosthetic devices and breast reconstruction, including surgery of the healthy breast to achieve symmetry. Coverage may be limited to six years following the date of the mastectomy.	38.2-3418.4: Reconstructive surgery coverage is required for breast surgery.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
816	Benefits for routine gynecological care	Requires carriers to permit a woman to have direct access to gynecological care from an in-network obstetrician/ gynecologist or other non-physician, including a certified nurse midwife, who is not her primary care physician; requires an obstetrician/ gynecologist to confer with a primary care physician		44-302.03: Health plans must permit women direct access for gynecological care to a gynecologist or advance practice registered nurse without referral by a primary care provider	40 P.S. s 991.2111: Managed care organizations must provide direct access to obstetrical and gynecological services without prior approval from a primary care provider	
817	Coverage for child wellness services	Insurers must include child wellness services in a family policy. Minimally, this must include coverage for immunizations, PKU test, screening tests (tuberculosis, anemia, lead toxicity, hearing & vision), universal hearing screening of newborns; a physical exam, developmental assessment & parental anticipatory guidance services at each visit; and lab tests. Insurers may impose copayments but no deductible	18-3554 & 18-3558: Childhood immunizations must be covered to age 18. Mandatory coverage for lead screening tests for children at age 1, with additional tests to age 6 for those at high risk.	35-530; 35-1101; 35-1102: Immunizations and blood tests for newborns; unlimited visits to age 12; three annual visits age 12 to 18.	40 P.S. 3503: Immunizations must be covered.	38.2-3411: Immunizations must be covered. Well child care to age 6 must be covered and exempt from deductibles and coinsurance.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
818	Benefits for treatment of cleft lip and cleft palate	Every hospital or major medical insurance policy must include benefits for inpatient or outpatient expenses arising from the management of cleft lip, palate, or both	DPH Reg. 69.4: Managed care organizations must have a policy assuring access to specialty pediatric outpatient centers for treatment of cleft lip and palate as determined to be medically necessary.		40 P.S. 772: Mandatory coverage for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.	38.2-3411: Health policies must cover Inpatient and outpatient dental, oral surgical, and orthodontic services which are medically necessary for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia.
819	Coverage for outpatient services and second opinions	Health insurers must cover a second opinion when required by a utilization review program and outpatient coverage for a service for which a hospital admission is denied				
820	Benefits for prosthetic devices and orthopedic braces.	Individual and group contracts written by a non-profit health service plan must provide benefits for prosthetic devices and orthopedic braces				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
821	Diagnostic and surgical procedures for bones of face, neck, and head	Health insurers must cover face, neck, and head bone and joint conditions if other skeletal bones and joints are covered, and if the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.				38.2-3418.2: Head / neck bone disorders, including face and jaw must be covered.
822	Coverage for diabetes equipment, supplies, and self-management training	Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self-management training and educational services, including medical nutrition therapy.	18-3559A: If prescription drugs are covered, equipment and supplies for the treatment of diabetes must also be covered.	31-3002: Requires health benefit plans to provide coverage for the equipment, supplies and other outpatient self-management training and education, including medical nutritional therapy.	40 P.S. 764e: Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self-management training and educational services, including medical nutrition therapy.	38.2-3418.10: Coverage required for equipment, supplies and self-management training.
823	Coverage for osteoporosis prevention and treatment	Carrier shall include coverage for qualified individuals for bone mass measurement when requested by a health care provider				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
824	Coverage for maintenance drugs	Carrier shall allow the insured to receive up to a 90-day supply of a prescribed maintenance drug in a single dispensing, except for new prescriptions or changes in prescriptions. If carrier increases copayment, they shall proportionally increase the dispensing fee.				
825	Coverage for detection of prostate cancer	Mandatory coverage for prostate screening for men who are between 40 and 75 years of age or who are at high risk for prostate cancer	18-3552: Mandatory prostate cancer screening for enrollees age 50 or above.	A14-491: Mandatory prostate cancer screening benefits that comply with the guidelines established by the American Cancer Society.		38.2-3418.7: Coverage required for annual PSA test for men age 50 and older and those age 40 and older at high risk.
826	Coverage for contraceptive drugs and devices	Mandatory coverage for any FDA-approved, prescription contraceptive drug or device and related services. Exempts religious organizations.	18-3559: Mandatory coverage for FDA-approved prescription contraceptive drugs, devices and outpatient contraceptive services; exempts religious employers.			38.2-3407.5: If prescription drugs are covered, all FDA-approved, prescription contraceptives must be covered.

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
827	Coverage for patient cost for clinical trials	Mandatory coverage for routine costs to an enrollee in a clinical trial for a life-threatening condition or prevention and early detection of cancer	18-3559G: Mandatory coverage for routine patient care costs for covered items and services for enrollees engaging in clinical trials for treatment of life threatening diseases.			38.2-3418.8: Mandatory coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer.
828	Coverage for general anesthesia for dental care under specified conditions	Coverage must be provided for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to an enrollee or insured under specified conditions.				38.2-3418.12: Mandatory coverage of anesthesia for dental procedures for children.
829	Coverage for detection of chlamydia	Coverage shall be provided for an annual routine chlamydia screening test for women who are under the age of 20 if they are sexually active and at least 20 if they have multiple risk factors; and for men who have multiple risk factors				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
830	Referrals to specialists	Plans that don't allow direct access to health care specialists must establish and implement a procedure by which insureds can obtain a standing referral to a health care specialist, including an OB/GYN	18 s 3348: Plans that don't allow direct access to health care specialists must establish and implement a procedure by which insureds can obtain a standing referral to a health care specialist		40 P.S. s 991.2111: Managed care plans must adopt procedures by which an enrollee with a life-threatening, degenerative or disabling disease or condition may receive a standing referral to a specialist with clinical expertise in treating the disease or condition.	38.2-3407.11:1: Health plans must permit any covered individual to obtain a standing referral, to a specialist if the determined by the primary care physician to be appropriate
831	Non-formulary drugs or devices	Health plans that limit prescription coverage to a formulary must establish & implement a procedure for an enrollee to obtain a drug or device that isn't on the plan's formulary when there is no equivalent drug or device in the formulary, an equivalent drug is ineffective or has caused an adverse reaction			40 P.S. s 991.2136: Plans using a drug formulary must have a written policy that includes an exception process by which a health care provider may prescribe and obtain coverage for the enrollee for specific drugs and medications not included in the formulary when the formulary's equivalent has been ineffective in the treatment of the enrollee's disease or if the drug causes adverse reactions.	38.2-3407.9:01: Plans must establish a process to allow an enrollee to obtain, without additional cost-sharing non-formulary prescription drugs if the formulary drug is determined by the plan and the prescribing physician, to be an inappropriate therapy for the enrollee's medical condition

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
832	Coverage for mastectomies	Requires carriers to cover at least 1 home health visit within 24 hrs. after discharge for a patient who had <48 hrs. of inpatient hospitalization after a mastectomy or surgical removal of a testicle, or who undergoes either procedure on an outpatient basis			40 P.S. 764d: If mastectomy is covered, post surgical hospital stay must be covered. Required coverage for a medically necessary home health care visit within 48 hours after a mastectomy.	38.2-3418.6: If mastectomy is covered, post surgical hospital stay of 48 hours must be covered. Plan must cover complications related to a mastectomy.
833	Extension of benefits	If an individual's coverage terminates, the plan must continue coverage for up to 12 months for treatment begun before termination related to disability, a claim in progress, or hospital confinement, up to 30 days for already ordered glasses or contact lenses, up to 90 days for an accident occurs while the individual is covered or a course of treatment begun before termination; up to 60 days or the end of the billing quarter for orthodontia				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
834	Coverage for prostheses	Requires carriers to provide coverage for a prosthesis prescribed by a physician for a member who has undergone a mastectomy & has not had breast reconstruction	18 s 3563: If mastectomy is covered, breast prostheses must be covered	31-3832: If mastectomy is covered, breast prostheses must be covered	40 P.S. 764d: Required coverage for breast prosthesis after mastectomy.	38.2-3418.6: Plan must cover medically necessary prostheses related to a mastectomy.
835	Coverage for habilitative services for children under 19 years of age	Requires carriers to provide coverage of habilitative services for children under the age of 19 years with a congenital or genetic birth defect, including autism & cerebral palsy, and may do so through a managed care system; carriers must provide notice annually to its members about the required coverage; carriers are not required to reimburse for habilitative services delivered through early intervention or school services; carriers denying payment for services because it is not a congenital or genetic birth defect is considered an adverse decision.				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
836	Hair prosthesis	Requires carriers to provide one hair prosthesis at a cost not to exceed $350 for a member whose hair loss results from chemotherapy or radiation treatment for cancer				
837	Colorectal cancer screening coverage	As of July 1, 2001, carriers shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (ACS)	18-3559C: Mandatory coverage for colorectal cancer screening for persons 50 years of age or older and those at high risk for colon cancer.	Act 14-233: Mandatory coverage for colorectal cancer screening for policyholders residing in the District in accordance with the American Cancer Society guidelines.		38.2-3418.7: Coverage required for risk groups established by the American College of Gastroenterology.
838	Hearing aid coverage for a minor child	As of October 1, 2001, carriers shall provide coverage for hearing aids for a minor child covered under a policy if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. Carriers may limit the benefit to $1,400 per hearing aid for each hearing-impaired ear every 36 months				

Exhibit 1 – Comparison of State Mandates

Maryland Subsection	MD Section & Benefit Addressed	Maryland Mandate	Delaware Mandate	District of Columbia Mandate	Pennsylvania Mandate	Virginia Mandate
839	Coverage for treatment of morbid obesity	Carriers must provide coverage for the treatment of morbid obesity through gastric bypass surgery or another surgical method that is: recognized by the NIH as effective for the long-term reversal of morbid obesity;				38.2-3418.13: Mandatory morbid obesity coverage for those 100lbs over their recommended weight, or with a specified body mass index in conjunction with obesity-related illnesses.
840	Coverage for medically necessary residential crisis services	Carriers must provide coverage for medically necessary residential crisis services that are intensive mental health & support services, provided to someone with a mental illness at risk of a psychiatric crisis; designed to prevent, shorten, or provide an alternative to a inpatient admission; provided on a short-term basis; and provided by licensed entities.				

Exhibit 2 – Maryland Insurance Article Section 15-1502

§ 15-1502.

(a) (1) The Commission shall conduct an evaluation of existing mandated health insurance services and make recommendations to the General Assembly regarding decision making criteria for reducing the number of mandates or the extent of coverage.

(2) The evaluation shall include:

(i) an assessment of the full cost of each existing mandated health insurance service as a percentage of the State's average annual wage and of premiums for the individual and group health insurance market;

(ii) an assessment of the degree to which existing mandated health insurance services are covered in self-funded plans; and

(iii) a comparison of mandated health insurance services provided by the State with those provided in Delaware, the District of Columbia, Pennsylvania, and Virginia.

(3) The comparison described in paragraph (2)(iii) of this subsection shall include:

(i) the number of mandated health insurance services;

(ii) the type of mandated health insurance services;

(iii) the level and extent of coverage for each mandated health insurance service; and

(iv) the financial impact of differences in levels of coverage for each mandated health insurance service.

(4) On or before January 1, 2004, and every 4 years thereafter, the Commission shall submit a report of its findings to the General Assembly, subject to § 2-1246 of the State Government Article.

(b) The General Assembly may consider the information provided under subsection (a) of this section in determining:

(1) whether to enact proposed mandated health insurance services; and

(2) whether to repeal existing mandated health insurance services.

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